UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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MARK NUNEZ, et al.,

Plaintiffs,

DECLARATION OF CHRISTOPHER MILLER

-against-

CITY OF NEW YORK, et al.,

11 Civ. 5845 (LTS)(JCF)

Defendants.

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UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

-against-

CITY OF NEW YORK and NEW YORK CITY DEPARTMENT OF CORRECTION,

Defendants.

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STATE OF NEW YORK)
:SS:
COUNTY OF QUEENS)

CHRISTOPHER MILLER declares pursuant to 28 U.S.C. Code §1746 under penalty of perjury that the following is true and correct:

1. I am the Deputy Commissioner of Classification, Custody Management and Facility Operations with the New York City Department of Correction ("DOC"), a position that I have held since July 25, 2022. Among my responsibilities is oversight of the intake processes at DOC.

2. I submit this declaration in response to the Court's order that "Defendants . . . file [a] status report[] . . . regarding the status of their continued efforts to implement reliable Intake tracking systems for new admissions and inter/intra facility transfers . . . by April 17, 2023." This is my third report on Intake, the first was on February 8, 2023, and the second on March 20, 2023.

A. New Admissions

3. Procedures for new admissions have not changed since my March 20, 2023 Declaration.

4. Our numbers for the period March 11, 2023 (since I last reported to the Court) to April 14, 2023, indicate that DOC is meeting its 24-hour obligation for new admissions. According to the New Admission Dashboard, 1,633 new male admissions were housed in the Eric M. Taylor Center ("EMTC") during that 35-day period, an average of 47 a day. Of those, only two (.1 percent) were housed beyond 24 hours, and the average time was 14.17 hours; excluding clock stoppages.[1] The two outliers were housed in 24 hours:49 minutes and 24 hours:20 minutes respectively.

5. The numbers for the Rose M. Singer Center ("RMSC"), where women are first admitted, show much the same story. According to the New Admission Dashboard, 126 new admissions were housed in RMSC during the 35-day period, an average of less than four per day. Of those, none was housed beyond 24 hours; the average time was 11.17 hours, again excluding clock stoppages.[2]

6. The Nunez Compliance Unit ("NCU") has continued to audit the intake process at EMTC to ensure that data is being entered accurately in the Dashboard and that the 24-hour requirement

[1] As before, these numbers use as a starting point the time when individuals came into our custody at the courthouse, and not the time that they arrived at EMTC. We stop the 24-hour "clock" when an event outside our control makes it impossible to continue to process an individual. In the recent 35-day period, there were 115 such stoppages: 69 for court, 16 for hospital, 2 for UrgiCare, and 28 for refusals.

[2] There were 28 clock stoppages: 12 for court, 4 for hospital, and 12 refusals.

is being met. Since my last declaration, there were three audits, one on March 12, 2023, one on March 27, 2023, and one on April 10, 2023. As before, the audits compared Dashboard entries with times taken from EMTC's Genetec surveillance system. On March 12, 11 individuals were tracked. All 11 were housed within 24 hours. For all 11, the arrival time and housing time as shown on the Dashboard coincided with the arrival time and housing time obtained from Genetec footage within the 20 minute grace period.

7. Eleven individuals were tracked at EMTC on March 27. Again, all 11 were housed within 24 hours. For all 11, the Dashboard arrival time coincided with the Genetec arrival time within 20 minutes. Five Dashboard housing times coincided with the Genetec arrival times within the 20 minutes; the other six did not. For three of those six, the Dashboard time showed that the individual was housed before he actually was (as indicated on the Genetec footage), and for the other three, the Dashboard time showed that the individual was housed after he actually was (as indicated on the Genetec footage).

8. Five of the six errors on March 27 were made by the same officer. The officer left the Dashboard to take on another assignment and estimated the housing times on her return. The officer has received a corrective interview from the facility Warden and admonished that future errors will result in reassignment. Significantly, there is no indication that the Dashboard was being "manipulated" to make non-compliant individuals appear to be compliant. As noted, for three of the six errors, the Dashboard indicated that the individual was in intake longer than he actually was.

9. The third audit took place on April 10, 2023. Again 11 people were tracked, and all 11 were housed within the 24 hour period. For all 11, the Dashboard arrival time coincided with the Genetec arrival time within 20 minutes. For 10 of the 11, the Dashboard housing time coincided

with the Genetec housing time within 20 minutes. The Dashboard housing time for the discrepant individual was one hour and 1 minute before the Genetec time housing time.

B. Inter/Intra Facility Intake

10. We are continuing to finetune the inter/intra tracking system. On March 27, I sent out a memorandum reconfirming the required steps. The memorandum emphasizes: (i) that each facility is responsible to record the time an individual enters and leaves intake area in the Inmate Tracking System ("ITS") using the bar code on the individual's accompanying card; (ii) that direct oversight of the ITS tracking system is the responsibility of the assigned Captain; and (iii) that the facility Warden has ultimate responsibility for intake tracking.

11. Staff are still not entering data in the ITS system as consistently as they should be, so that we are not yet able to run daily reports like those for new admissions. To rectify this problem, I have asked our IT unit to develop a report showing data entry failures. The report identifies all inter-facility transfers on a day (say, April 10, 2023) and then looks to see the entries for that date in the ITS system. If the requisite four entries are not there (e.g., entered intake in Facility A, left intake in Facility A, entered intake in Facility B, and left intake in Facility B), the facility is notified. I have assigned my two Associate Commissioners to monitor the process. And I have instructed the Warden of each facility to address this topic at roll calls during the next three weeks. In addition, individuals who fail to enter data (or enter it improperly) will be held accountable. My expectation is that data entry issues will be resolved and that we should be able to produce daily Inter/Intra facility reports in May.

12. In my March 20 declaration, I reported having established a team of three officers to monitor the inter/intra facility intake process. The team has now been expanded to five to give

coverage seven days a week, 24 hours a day. The team has access to Genetec and watches the intake units in the facilities to see that no one is there for an extended period.

13. On April 10, I sent out a memorandum directing all facilities to submit an intake report six times each day (12:00a.m., 4:00a.m., 8:00a.m., 12:00p.m., 4:00p.m., and 8:00p.m.). The five-person team reviews those reports to determine whether any incarcerated individual is in intake too long.[3] If an individual appears on two consecutive reports (e.g., 8:00a.m. and 12:00p.m.), the facility is notified that the individual's movement must be expedited. Inter-facility transfers do not require the steps that are necessary for processing new admissions - - there is no need for fingerprinting, photographing, issuing clothing, completing forms, or medical/ mental health screenings. Absent unusual circumstances, transfers should be accomplished well within the allotted time.[4] Intra-facility transfer generally takes less time because there is no need for transportation.

14. At my direction, an audit was conducted of inter-facility transfers on April 11 and 12 using the four-hour reports. The audit used the most conservative assumption: anyone who appeared on a four-hour report at 4:00p.m. but not on a previous 12:00p.m. report was assumed to have arrived in intake at 12:01p.m., and anyone who appeared on a 4:00p.m. report but not a subsequent 8:00p.m. report was assumed to have left intake at 7:59p.m. Twenty-four individuals were tracked. Of the 24, only three were in intake for more than 12 hours. - - i.e., they appeared on more than

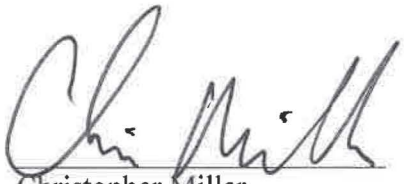
[3] The team also verifies the accuracy of the four-hour reports by comparing them to Genetec footage.

[4] An example of an unusual circumstances is individual "J.A." On April 11, J.A. was scheduled to be transferred from EMTC to the Anna M. Kross Center ("AMKC") following a gang-related fight in his EMTC unit. Records show that he arrived in AMKC intake before 4:00a.m. and that an attempt was made to house him in Quad Upper 1. That failed apparently because J.A. saw someone in the unit whom he feared and requested protective custody. J.A. was then taken back to AMKC intake while his protective custody request was considered. Protective custody was denied, and, sometime before midnight, he was placed in Quad Upper 10 at AMKC, where he now resides.

one or two four-hour reports. One individual was there at most 20 hours, and the other two were there at most 24 hours.[5]

15. I have also instructed each facility to send me each day a copy of its Intake Log Book showing that the Warden, Deputy Warden, Tour Commander (typically an Assistant Deputy Warden), and Intake Captain have made their required rounds in the intake area. Their regular presence provides oversight and sends a message about the importance of accurate data entry.

Dated: April 17, 2023
East Elmhurst, New York



Christopher Miller

[5] One of those individuals in intake for up to 24 hours was J.A; the other was scheduled to move from AMKC to the George R. Vierno Center ("GRVC"). The transfer to GRVC proved unsuccessful (again it appears the individual expressed fears), and he was rerouted to protective custody in VCBC, where he now resides.